Claims Clues

A Publication of the AHCCCS Claims Department August, 1999

ESRD Facility Claims Face Prepayment Review

AHCCCS is conducting a prepayment review of all fee-for-service claims submitted by free-standing dialysis facilities (provider type 41).

Documentation justifying medical necessity will be required for medical review of claims for the following services:

- EPO greater than 10,000 units/ administration
- EPO greater than 100,000 total units
- Hematocrit rolling average (HRA) > 36.0
- Blood or laboratory tests on blood (revenue code 390)
- All drugs except Calcijex and Infed

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- All vaccines except influenza and pneumonia
- Bone density tests, EKG, and nerve conduction tests
- Hemodialysis treatments exceeding 14 units in one month

Services for which medical documentation is not provided will be denied.

Providers who need to submit documentation after the claim has been submitted to AHCCCS must write the AHCCCS Claim Reference Number (CRN) on the documentation. The documentation will be imaged and linked to the claim image.

Dialysis facilities are reimbursed a composite rate. Services included in the composite rate may not be billed separately unless the services are provided more frequently than specified by policy. AHCCCS follows Medicare policy for billing and reimbursement of dialysis services. ❒

Initial Claim To Be Due 6 Months from DOS

Effective with claims with an ending date of service on or after October 1, 1999, the initial fee-for-service claim for services provided to an AHCCCS recipient must be received by AHCCCS not later than 6 months from the ending date of service unless the claim is a retro-eligibility claim. For hospital inpatient claims, "date of service" means the date of discharge of the patient.

Claims with dates of service prior to October 1, 1999 remain subject to the 9-month initial claim submission deadline.

Regardless of dates of service, provider may resubmit a claim up to 12 months from the date of service, unless the claim is a retro-eligibility claim. If a claim does not achieve clean claim status within 12 months, AHCCCS is not liable for payment.

A retro-eligibility fee-for-service claim for a categorically eligible recipient with an ending date of service on or after October 1, 1999 is considered a timely submission if the initial claim is received by AHCCCS no later than 6 months from the AHCCCS date of eligibility posting. For dates of service prior to October 1, 1999, the initial submission deadline remains at 9 months from the eligibility posting date.

Regardless of dates of service, retro-eligibility fee-for-service claims for categorically eligible recipients must attain clean claim status no later than 12 months from the eligibility posting date.

The change to the 6-month deadline was approved earlier this year by the Arizona Legislature and signed into law by Governor Jane Dee Hull. The intent of the measure is to bring the AHCCCS Administration's claim submission time frames into line with the time frames established by the AHCCCS-contracted health plans and program contractors. ❒

New Manuals On Their Way

The *AHCCCS Fee-For-Service Provider Manual* is on its way to providers!

A free copy is being sent to each registered provider's correspondence address.

Non-providers may purchase the manual for $75.00. Send a check along with information on where to mail the manual to:

AHCCCS Claims Policy Unit
701 E. Jefferson St.
Mail Drop 8100
Phoenix, AZ 85034 ❒

ESRD Facility Claims Require CPT/HCPCS Codes

AHCCCS requires that certain services provided by ESRD facilities be billed with a CPT or HCPCS code that further defines the services described by the revenue code listed on the UB-92 claim form.

Units must be consistent with CPT/HCPCS code definitions.

The table below summarizes revenue – CPT/HCPCS code requirements for ESRD facilities.

This table updates the table in Chapter 20, Page 20-6 of the *AHCCCS Fee-For-Service Provider Manual* dated July, 1999. Please make a note of the changes in CPT/HCPCS code requirements for revenue codes 304 (Lab/NR Dialysis) and 636 (Drugs/Detail Coding). . ❐

UB-92 Revenue – CPT/HCPCS Requirements for ESRD Facilities	
Revenue Code	**CPT/HCPCS Codes**
270 – Med-Sur Supplies & Drug Admin	Various
304 – Lab/NR Dialysis	82962
320 – Dx X-Ray	78350, 78351
380 – Blood	P9022
381 – Blood/Pkd Red	P9021
382 – Blood/Whole	P9010
383 – Blood/Plasma	P9017, P9018
384 – Blood/Platelets	P9019, P9020
385 – Blood/Leukocytes	P9016
386 – Blood/Components	P9013
387 – Blood/Derivatives	P9012
390 – Blood/Stor-Processing	86000 – 86999
636 – Drugs/Detail Coding	J0150, J0280, J0290, J0340, J0360, J0510, J0530, J0610, J0630 – J0635, J0690 – J0697, J0710, J0715, J0745, J0780, J0895, J0970, J1050, J1070 – J1080, J1160 – J1170, J1240, J1380 – J1410, J1580, J1630 – J1631, J1720, J1760 – J1780, J1790 – J1800, J1840, J1890, J1940, J2175, J2270, J2320 – J2322, J2510, J2540, J2550 – J2560, J2680 - J2700, J2720, J2765, J2920 – J2930, J2970, J3000 – J3010, J3070, J 3120 – J3130, J3230, J3250 – J3260, J3280 – J3301, J3360, J3365 – J3370, J3410 – J3430, J3490, J7030 – J7070, J7130, Q9920 – Q9940, 90657 – 90660, 90732, 90744 – 90747
730 – EKG/ECG	93000
771 – Vaccine Administration	G0008, G0009, G0010
922 – EMG	95900, 95903, 95904

Coding Corner

The AHCCCS Administration has made the following changes to its Reference subsystem:

- The daily maximum for code E1399 (durable medical equipment, miscellaneous) has been changed to one.
- The following four codes will be changed from category of service 12 (Pathology and laboratory) to category of service 01 (Medicine) effective October 1, 1999:

G0004 - Patient demand single or multiple event recording with pre-symptom memory loop and 24 hour attended monitoring, per 30-day period; includes transmission, physician review, and interpretation.

G0005 - Patient demand single or multiple event recording with pre-symptom memory loop and 24 hour attended monitoring, per 30-day period; recording (includes hook-up, recording, and disconnection).

G0006 - Patient demand single or multiple event recording with pre-symptom memory loop and 24 hour attended monitoring, per 30-day period; 24-hour attended monitoring, receipt of transmissions, and analysis.

G0007 - Patient demand single or multiple event recording with pre-symptom memory loop and 24 hour attended monitoring, per 30-day period; physician review and interpretation only. ❐

Providers Must Authorize Electronic Remittance

Providers must complete and sign an authorization form in order to receive the AHCCCS Fee-for-Service Remittance Advice in an electronic format.

The authorization form is attached to this issue of *Claims Clues*.

Providers who wish to receive an electronic Remittance Advice should complete the form and submit it as directed. The authorization form must be signed by the provider or the provider's designated agent.

Authorization Form Attached

The Remittance Advice will be transmitted to providers via the Internet to the provider's electronic mail (email) address.

The Remittance Advice will be a file attachment to an email, and it will retain its current content.

Providers who select the electronic Remittance Advice will no longer receive a paper copy of the document.

Electronic transmission of the Remittance Advice does **not** include electronic deposit of reimbursement checks. Reimbursement checks will continue to be mailed to the provider's pay-to address.

AHCCCS expects to make the electronic Remittance Advice available by October 1. ❒

Providers Must Be Present at AHCCCS Hearings

Billing services and similar entities may not represent providers at AHCCCS hearings conducted by the Arizona Office of Administrative Hearings.

A provider will be considered to have defaulted if an employee of the provider is not present at these hearings.

A billing service representative may attend the hearings and advise the provider.

The Arizona Supreme Court has ruled that providers who wish to cross-examine witnesses and make opening and closing statements at AHCCCS hearings do not need legal representation.

The Supreme Court said earlier that opening and closing statements and cross-examination of witnesses at AHCCCS hearings could only be done when there is legal representation.

The AHCCCS Administration sought an exception to the rule for AHCCCS contractors and providers. The Arizona Supreme Court granted that exception.

Effective July 1, all AHCCCS hearings are conducted by the Office of Administrative Hearings, an independent state agency.

An administrative law judge will conduct the hearing, decide the facts, apply law, and make a recommendation to the AHCCCS director, who will issue the director's decision.

A petition for a re-hearing must be submitted within 30 days of the director's decision. The director will determine whether to amend the decision or order a re-hearing.

The AHCCCS Office of Legal Assistance (OLA) no longer conducts hearings. However, providers must still file grievances and appeals with OLA. The OLA Informal Resolution Unit will continue to render written grievance decisions.

For further information regarding hearings, contact:

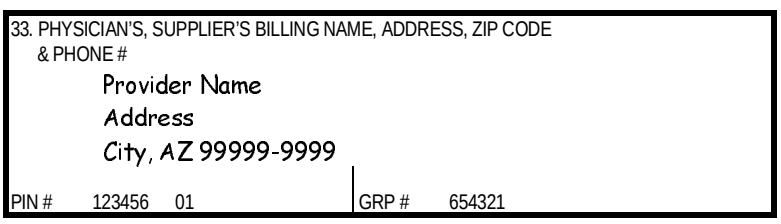
Office of Administrative Hearings
1400 W. Washington St.
Suite 101
Phoenix, AZ 85007
Telephone: (602) 542-9826
Fax: (602) 542-9827 ❒

Service, Billing Provider IDs Must Be Entered Carefully

Providers who use a group biller to submit claims to AHCCCS must make sure that the appropriate AHCCCS provider ID numbers are entered correctly on the HCFA 1500 claim form.

The *service* provider's six-digit AHCCCS provider ID number and two-digit locator code must be entered next to next to "PIN #" in Field 33.

The *billing* provider ID (group biller ID) must be entered next to "GRP#" in Field 33. ❒



Providers Must Keep 3 Addresses Current

AHCCCS maintains three types of addresses for each provider (except group billers), and providers must notify the AHCCCS Provider Registration Unit of changes to any of these addresses.

For most providers, AHCCCS maintains a correspondence address, a pay-to address or addresses, and a service address or addresses. AHCCCS maintains a correspondence address and a pay-to address for group billers.

The *correspondence address* is the address where all correspondence, except checks and remittance advices, is mailed.

Each provider has only one correspondence address, regardless of the number of service addresses. If the provider changes practices, partnerships, or place of practice and does not change the correspondence address, new correspondence will not be directed to the correct address.

The *pay-to address* is the address on the reimbursement check from AHCCCS. Each pay-to address is associated with at least one service address and may be associated with multiple service addresses.

Providers must ensure that the pay-to address(es) on file with AHCCCS is (are) up-to-date.

The *service address* is the business location where the provider sees patients or otherwise provides services. A locator code (01, 02, 03, etc.) is assigned to each service address.

Each service address locator code is tied to a pay-to address. The locator code must be included as part of the provider ID on every claim submitted to AHCCCS.

Example:

A provider with AHCCCS provider ID 123456 sees patients at two service addresses.

When the provider submits a claim to AHCCCS, the provider ID would be entered on the claim form as 123456-01 or 123456-02, depending on the address where the service was provided.

As new service addresses are reported to AHCCCS, additional locator codes are assigned. When a service address is no longer valid, the provider must notify AHCCCS, and that service address locator code will be end dated.

If the provider does not include the service address locator code on a claim, the AHCCCS system will default to locator code 01, even if that service address is end dated. The claim payment will be directed to the pay-to address associated with the end-dated service address locator code, and payment may be misdirected.

Providers should ensure that the correct locator code is included on each claim.

Example:

The provider with AHCCCS provider ID 123456 sees patients at two service addresses, Site A and Site B. Site A is assigned locator code 01, and Site B is assigned locator code 02. The provider subsequently stops providing services at Site A but continues to see patients at Site B.

Even though the provider is working at only one service address, the provider must enter the provider ID and locator code on each claim as 123456-02. If the provider entered only the six-digit ID on the claim form, the locator code would default to 01, the end-dated locator code for Site A. This could result in misdirected reimbursement to the pay-to address linked to locator code 01.

All requests to change address information must be submitted in writing on the provider's letterhead and signed by the provider or the provider's authorized agent. The name of the authorized signer must be on file with the Provider Registration Unit. Change requests submitted by someone not authorized by the provider cannot be accepted. ❐

Phone Number Correction

The telephone number for University Family Care is listed incorrectly in Exhibit 1-1 of the *AHCCCS Fee-For-Service Provider Manual*.

The correct toll-free number is (888) 708-2930. Please make a note of this change. ❐

Cover Sheet Needed When Faxing PA Information

Providers who fax documentation to the AHCCCS Prior Authorization Unit should send a cover sheet with the documentation.

The cover sheet should list the provider's name and AHCCCS provider ID number, the name of a contact person, a telephone number (including area code) and a fax number.

This will enable an AHCCCS Prior Authorization nurse to contact the provider in case additional information is needed before services can be authorized.

The PA Unit's fax number is (602) 256-6591. . ❐

Authorization for Electronic Transmission
Of AHCCCS Fee-For-Service Remittance Advice

I Hereby request and authorize the AHCCCS Administration to transmit my Fee-For-Service Remittance Advice via the Internet to the electronic mail (email) address listed below. I understand that I will no longer receive a paper copy of my Remittance Advice once I begin receiving my Remittance Advice electronically.

I understand that although my Remittance Advice will be transmitted electronically, my reimbursement check(s) will continue to be delivered by the U.S. Postal Service to the pay-to address(es) on file with the AHCCCS Administration Provider Registration Unit.

I understand that it is my responsibility to notify the AHCCCS Administration Provider Registration Unit in writing of any change in my email address.

Provider/Group Name: _____

AHCCCS Provider Identification Number: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Telephone: (____) _____ Fax: (____) _____

Name of Contact Person: _____

Email address: _____

Signature of Provider
Or Authorized Representative: _____

Date: _____

Mail this form to: AHCCCS Provider Registration Unit
MD 8100
701 E. Jefferson St.
Phoenix, AZ 85034

or

Fax this form to: AHCCCS Provider Registration Unit
(602) 256-1474

Please allow 10 working days for implementation of this change.